GEORGIA BETTER HEALTH CARE
APPLICATION INSTRUCTIONS

PRACTICE INFORMATION PAGE

Practice Name: If the application is for a group practice, enter the name of the practice here. If the practice is planning on future expansion, a group name should be entered here.

Individual Practitioner: Enter the name of the enrolling solo practitioner or the individual who is joining the group practice.

Tax ID/SSN: Enter the Tax Identification Number (TIN) of the payee. If the payee is an individual provider, the Social Security Number (SSN) can be used. *The location address and Federal tax ID number on the GBHC application must match the enrollment information for the Medicaid/ program*

Practice Address & Telephone Numbers: This information will be printed on the GBHC member's Medicaid card. Enter the physical address of your office. (A post office box is not acceptable.) **A separate application packet is required for each location**. Enter the area code and phone number members may call to schedule an appointment AND the area code and telephone number members may call after regular office hours to reach a doctor or other medical personnel.

Mail-To Address: The address to which written correspondence should be sent. Either a street address or a post office box is acceptable.

Office Hours: **List only those office hours when a provider is available <u>in the office</u> to see patients**. Include lunch breaks when you do not provide routine medical care.

Accepting New Patients Established Patients Only: ***Accepting New Patients*** if you wish to accept new patients through the auto-assignment process or by patients selecting you as their primary care provider. ***Established Patients Only*** if you wish to case manage only those patients already established with your practice. Members must complete a *Provider Selection Form* requesting assignment to your practice. This form must be signed by the member along with the provider and submitted to GBHC Member Services.

Patient Type: Indicate the age range and gender(s) of patients you wish to case manage. This designation determines the type of patients matched to your practice in the auto-assignment process.

Contact Person: Enter the contact information of the person in your office that GBHC may contact if there are any questions regarding this application or other Georgia Better Health Care questions.

Check "yes" or "no": Has Georgia Medicaid ever placed any member of your practice on prepayment review status? **If "yes", please attach details.**

PRACTICE COMPOSITION

Provider Name, Medicaid #, License#, et. al List all physicians, nurse practitioners and physician assistants in the practice who are applying to participate in GBHC at this location. Include the enrolling provider(s):

- Name of the medical practitioner.
- Medicaid provider number* and Georgia professional license number.
- Check "yes" or "no" if Board Certified and list specialty.
- Enter the number of hours each provider works per week at the enrolling location.
- Enter the primary hospital for each physician that has Hospital Admitting Privileges.

If the individual practitioner does not have hospital admitting privileges, attach documentation that details his/her alternate arrangement for elective admissions for his/her patients. **You may photocopy the Practice Composition Page as necessary for additional applicants.**

**If the practice is a FQHC or RHC, enter the individual Medicaid number for each enrolling practitioner.*

AFTER HOURS TELEPHONE COVERAGE AGREEMENT

After Hours Arrangement: Provide a detailed description of the after hours coverage arrangement currently in effect for your practice.

ATTESTATION STATEMENT

Provider's Name: Print the name and title of the provider or the authorized representative of the group listed on page two of the application. For group practices, each medical provider listed on the application must have a completed Attestation Statement on file. **An original signature is required. This form must be completed by each enrolling provider.**

Mail Completed Application To:
ACS Provider Enrollment
P.O. Box 4000
McRae, GA 31055

GEORGIA BETTER HEALTH CARE APPLICATION

Please check one of the following options that indicate how you wish to enroll:

- ☐ **Create a new GBHC solo practice**
- ☐ **Create a new GBHC group practice (includes FQHC, RHC, Health Depts.)**
- ☐ **Individual practitioner joining an existing GBHC group practice**
- ☐ **Changing location address (Please submit documentation of this change)**

PRACTICE INFORMATION

Practice Name_____

Individual Practitioner Name _____

Practice Street Address_____Suite_____

City _____County_____ State _____ Zip Code_____

Office Telephone (_____)_____ Office Fax Number (____)_____
To be listed on GBHC Member's Medicaid Card

After Hours Telephone (_____)_____ E-Mail_____
To be listed on GBHC Member's Medicaid Card

Social Security #: _____ Date of Birth #: _____
(Individual joining a Group Practice)

Group GBHC #: _____ Federal Employer ID #: _____
(If group currently enrolled)

Check One: ☐ **ACCEPTING NEW PTS** ☐ **ESTABLISHED PTS ONLY**

Patient Type: **IM/FP** ☐**M/F 0-99** ☐ **M/F >14** **PEDS** ☐**M/F < 19** **GYN:**☐ **>14**
Check One ☐**M/F 2-99** ☐**M/F >21** ☐**M/F < 22** **Female Only**

Languages spoken (primary language first) _____ _____

PLEASE INDICATE ANY OF THE FOLLOWING SERVICES WHICH YOUR PRACTICE MAY BE ABLE TO PROVIDE (check all that apply)

☐ Sign Language ☐ Wheelchair Accessibility ☐Diabetes ☐ Asthma ☐ Other:_____

THE PERSON IN YOUR PRACTICE WHO SHOULD BE CONTACTED REGARDING GBHC ISSUES:

Name: _____ Title:_____

Telephone #: (_____)_____ E-Mail Address: _____

Has Georgia Medicaid ever placed any member of your practice on prepayment review status? ☐Yes ☐ No
(If "yes", please attach details.)

Georgia Better Health Care
After-Hours Telephone Coverage & Provider Accessibility Agreement

Georgia Better Health Care (GBHC) requires that participating Primary Care Case Managers provide patients with a method to contact the practice 24 hours a day, 7 days a week. The after-hours telephone line must connect or direct callers to the live voice of on-call **medical** personnel who will provide medical advice or triage, and either provide directly or refer members for necessary medical treatment. Access to after-hours medical advice and triage is intended to reduce fragmented, episodic care and unnecessary utilization of hospital emergency rooms for non-emergency care. (See Part II Policies and Procedures for Georgia Better Health Care services, **§ 902.5**). Additionally, providers must be available in the office to provide general medical care for a minimum of thirty (30) hours per week for primary care services. (See Part II Policies and Procedures for Georgia Better Health Care services, **§ 902.4)**

Office Hours: **(Please indicate only those times a primary care provider is available in the office to see patients.)**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							
Lunch	To	To	To	To	To	To	To

Please provide below a step-by-step description of the after-hours coverage arrangement in effect for your practice in accordance with GBHC contractual requirements. Please include all applicable information as referenced in **§ 902.5**. **Incomplete or insufficient information regarding your after-hours coverage will cause a delay in the review of this application.** Attach additional page(s) if necessary.

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PRACTICE COMPOSITION

Please list (including enrolling provider) all physicians, nurse practitioners, and physician assistants in the practice at this location who wish to participate in GBHC. (Please attach additional page(s) if necessary)

Provider Name	Medicaid Provider #	License #	Board Certified / Specialty	Number of Hours / WK This Office	Hospital ADM Privileges / OR Alternative arrangement
			Yes □ No □ Specialty:		Facility: From: To:
Alternative Arrangement:					
			Yes □ No □ Specialty:		Facility: From: To:
Alternative Arrangement:					
			Yes □ No □ Specialty:		Facility: From: To:
Alternative Arrangement:					
			Yes □ No □ Specialty:		Facility: From: To:
Alternative Arrangement:					

****GBHC PCPs must have hospital admitting privileges, or must have a formal arrangement with a physician who does have hospital admitting privileges and who agrees to abide by the GBHC authorization requirements. Please indicate the hospital where you have your primary admitting privileges or provide a description of your alternative arrangement.**

****Please list any additional locations and the total number of hours where the enrolling provider(s) has GBHC involvement. (Please attach additional page(s) if necessary)**

Provider's Name	Provider #	Location Address	Number of Hours

**** If a provider is no longer providing services at a particular location, please submit documentation of this change.**

APPLICANT NAME OR AUTHORIZED REPRESENTATIVE (Please Print / Type)

APPLICANT NAME OR AUTHORIZED REPRESENTATIVE (Signature)

DATE

Attestation Statement

1.

I hereby elect to participate in the Georgia Better Health Care (GBHC) program as a primary care provider (PCP) to deliver services to eligible Medicaid and PeachCare for Kids members. I certify that I am legally qualified and licensed to render the medical or remedial care or services authorized to be reimbursed under the GBHC category of service.

2.

I certify that the information in this application is a true, accurate and complete description of the process in effect for this practice. I understand that falsification, omission or misrepresentation of any information in this application will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions.

3.

I agree that any change in the after-hours telephone coverage arrangement or hours of primary care provider accessibility will be communicated, in writing, to the Department at least sixty (60) days before the change takes effect. I understand that failure to comply with all 24-hour coverage or provider accessibility requirements may be grounds for termination as a participating PCP in the GBHC program.

4.

In the event that I wish to discontinue any further participation in the Georgia Better Health Care program, I agree to give sixty (60) days written notice to the Department of such election to discontinue participation.

5.

I understand that the complete text, as now or hereafter amended, of the Department's Policies and Procedures Manual relating to Georgia Better Health Care is hereby incorporated, by reference, into this instrument. And that, otherwise, there are no promises, terms, conditions, or obligations other than those contained herein, and this agreement shall supersede all previous communications, representations or agreements either verbal or written, between the applicant and the Department of Community Health, Georgia Better Health Care Program.

6.

In consideration for case management services I elect to render pursuant to this agreement, the Department shall reimburse for such claims, and in such amounts, as meet the provisions of the Georgia State Plan for Medical Assistance, and the applicable terms and conditions for receipt of Medical Assistance published in the Georgia Better Health Care Policies and Procedures Manual and amendments thereto, in effect on the date the service is rendered.

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Printed Name of Applicant

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Signature of Applicant Date